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Delivery System Reform Incentive Payments (DSRIP) Menu

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April 10, 2012

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DSRIP Menu Outline

- A DSRIP Menu Vision
- DSRIP Structure
- DSRIP Menu
- Comments on the DSRIP
- DSRIP Menu Vision Revisited
- Resources/Contacts

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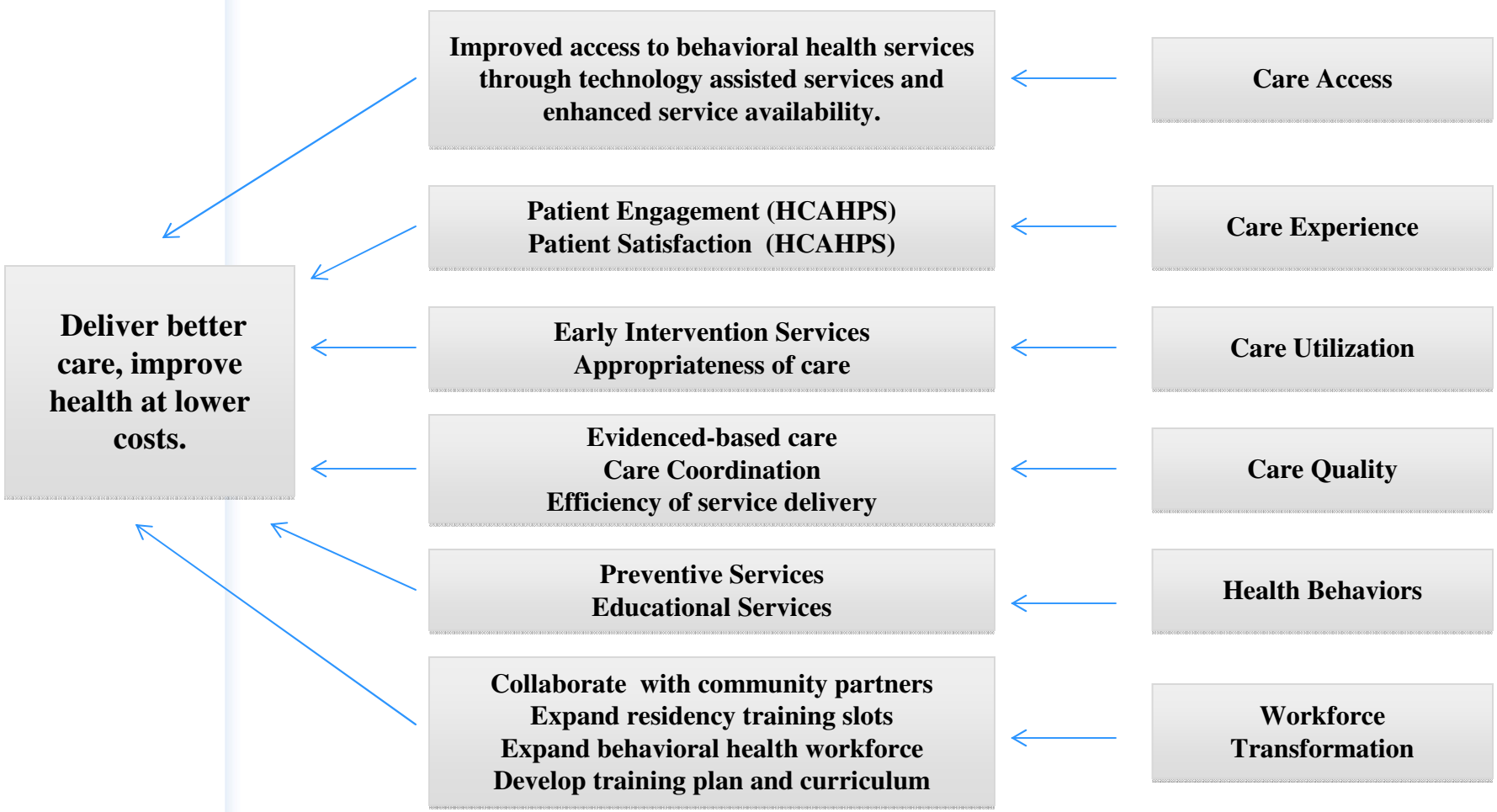
A DSRIP Menu Vision

Expand Behavioral Health Care Access: Driver Diagram



Measurements:

•30-day readmission rate for behavioral health/substance abuse.

• Admission rate for behavioral health/substance abuse.

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DSRIP Structure

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DSRIP Structure

Category I: Infrastructure Development

Lays the foundation for the delivery system through investments in people, places, processes and technology.

Category II: Program Innovation & Redesign

Pilots, tests and replicates innovative care models.

Category III: Quality Improvements

Disseminates up to four interventions in which major improvements can be achieved within four years.

Category IV: Population-based Improvements

Requires all RHPs to report on the same measures across six domains.

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DSRIP Structure

- The DSRIP Menu includes four categories.
- Each Category has 5-10 Project Areas.
- Each Project Area has approximately 1-10 Focuses/Interventions.
- Each Focus/Intervention has at least one corresponding measure.

	DSRIP CATEGORY			
	I	II	III	IV
Number of Project Areas	9	9	5	6
Number of Interventions /Focus Areas	27	32	12	15

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DSRIP Menu

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Category I: Infrastructure Development

- Expand health care access (primary and specialty care, behavioral health/substance abuse).
- Enhance HIE/HIT for Performance Improvement and Reporting Capacity.
- Implement/expand Telehealth.
- Develop a Patient-Centered Medical Home model infrastructure.
- Enhance Public Health Preventive Services and Emergency Management Services.
- Implement a Disease or Care Management Registry.

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DSRIP Category I – Infrastructure Development

	Project Area		Intervention	Outcome Measures
1	Expand Behavioral Health Access	A	Implement technology-assisted services (telemedicine, telephonic guidance) to support or deliver behavioral health. Develop individual health management strategies to address personal and social barriers impeding access to services.	# of patients receiving behavioral health services through new technology # of patients receiving health management intervention
		B	Provide an early intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care etc.).	% utilization of behavioral health and substance abuse services for the right patient, in the right setting, in a timely manner
		C	Enhance service availability (i.e., hours, clinic locations, transportation, mobile clinics) to appropriate levels of care.	% of behavioral health care encounters.

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DSRIP Category I – Infrastructure Development

	Project Area		Intervention	Outcome Measures
1	Expand Behavioral Health Access	D	Collaborate with community partners to explore and develop a long-term Crisis Intervention/Stabilization unit.	% of inpatient and outpatient behavioral health services
		E	Develop workforce enhancement initiative(s) to support access to providers (i.e., physicians, psychiatrists, psychologists LMSW, LRC, LMFT) in underserved markets and Areas.	# of behavioral health providers
		F	Expand residency training slots for psychiatrists, child psychiatrists, psychologists and mid-level behavioral health practitioners (LMSW, LPC, LMFT).	# of residents trained # mid-level providers trained

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DSRIP Category I – Infrastructure Development

	Project Area		Intervention	Outcome Measures
2	Expand Primary Care Access	A	Enhance service availability (hours, clinic locations, urgent care, transportation, mobile clinics) to appropriate levels of care.	# of primary care encounters Length of time to 3rd available routine appointment
		B	Develop a system for primary care provider recruitment and retention.	# of primary care providers # of primary care encounters
		C	Develop Workforce Enhancement Initiative(s) to Support Access to Providers in Underserved Markets and Areas (Nurse Practitioners, Physician Assistants, nurses, educators, etc.) to be integrated into primary care.	# of physicians trained # of providers trained

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DSRIP Category I – Infrastructure Development

	Project Area		Intervention	Outcome Measures
3	Expand Specialty Care Access	A	Enhance service availability (hours, clinic locations, transportation, mobile clinics).	# of specialty care encounters
		B	Implement facilitated referral programs and excellent communication between primary care and other health care consultants.	# of electronic specialty care referrals
		C	Develop and expand use of telehealth to increase access to care in fields consistent with CMS and Accreditation Standards.	# of patients receiving specialty care using telehealth
		D	Develop Workforce Enhancement Initiative(s) to Support Access to Providers in Underserved Markets and Areas.	# of specialty health providers

DSRIP Category I – Infrastructure Development

	Project Area		Intervention	Outcome Measures
4	Enhance Health Information Exchange and Health Information Technology for Performance Improvement and Reporting Capacity	A	Generate data reports to prioritize RHP decisions for quality improvement initiatives.	# of metrics
		B	Capture race, ethnicity and language as self reported.	# of clinical settings % of patient with race, ethnicity and language data reported
		C	Recruit and/or train staff to lead analyses (including data analytics, performance benchmarking, and implementation science) of population management and performance improvement methodologies.	# of people recruited and trained

DSRIP Category I – Infrastructure Development

	Project Area		Intervention	Outcome Measures
4	Enhance Health Information Exchange and Health Information Technology for Performance Improvement and Reporting Capacity	D	Facilitate coordination of care by leveraging health information exchange.	# of records available between inpatient and outpatient clinics
		E	Screen patients for health literacy using evidenced-base tool.	# of patients screened

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DSRIP Category I – Infrastructure Development

	Project Area		Intervention	Outcome Measures
5	Implement and/or Expand Telehealth	A	Establish a telehealth program/network to provide additional health care services (i.e., home health, self-care, and translation services).	# of patients receiving health care services through telehealth
		B	Use telehealth to deliver psychosocial and community-based nursing services to promote independence at home.	# of patients receiving psychosocial services

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DSRIP Category I – Infrastructure Development

	Project Area		Intervention	Outcome Measures
6	Implement Disease or Care Management Registry	A	Create longitudinal registry databases of health care utilization and services for patients with common chronic diseases and/or ambulatory sensitive conditions.	# of providers receiving monthly registry reports on their patients with selected conditions # of providers meeting monthly with panel manager and care team to red-flag patients to receive outreach by phone, mail or in-person.
		B	Collaborate with health departments to develop a longitudinal database of epidemiological data.	# of providers receiving monthly reports on their patients with selected conditions
		C	Use/Maintain the ImmTrac, Texas Immunization Registry.	# of patients reported in ImmTrac, Texas Immunization Registry

DSRIP Category I – Infrastructure Development

	Project Area		Intervention	Outcome Measures
7	Develop Patient-Centered Medical Home Model Infrastructure	A	Redesign care delivery, in accordance with medical home recognition program, or expand scope to a specified population/community.	# of clinics that will be using the medical home model with eligible patients assigned
		B	Promote education and training for providers and patients related to the Patient-Centered Medical Home model.	# of educational opportunities for providers and patients

DSRIP Category I – Infrastructure Development

	Project Area		Intervention	Outcome Measures
8	Enhance Public Health Preventive Services	A	Enhance service availability (hours, clinic locations, transportation, mobile clinics) to appropriate levels of care.	% of encounters

	Project Area		Intervention	Outcome Measures
9	Improve or Expand Emergency Medical Services	A	Reduce the transfer time from ED to ED by ambulance to 2 hours or less. Reduce and eliminate the number of transfers by private vehicle from ED to ED.	Average transfer time by ambulance Proportion of transfers from ED to ED by private vehicle

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Category II: Program Innovation and Redesign

- Strategies to impact Potentially Preventable Events.
- Mechanisms to test provider financing models.
- Health promotion and disease prevention models.
- Innovations in provider training and capacity.
- Behavioral/Substance Abuse care models.
- Telehealth innovations.
- Strategies to reduce inappropriate Emergency Department use.
- Supportive care models.

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DSRIP Category II – Program Innovation and Redesign

	Project Area		Intervention	Outcome Measures
1	Reduce Potentially Preventable Admissions/ Readmissions (PPA/PPR)	A	Implement an evidence-based care coordination model in a target population.	Potentially preventable admissions rate and potentially preventable readmissions rate
		B	Implement post-discharge support for target population admitted to a hospital.	% of incidence of presentation to ED due to lack of medication availability and understanding, and delayed follow-up by providers
		C	Implement programs that link patients with multiple hospitalizations in one year to home/non-hospital resources that will reduce demand for inpatient care.	% admitted of top 5 PPR % of patients satisfied with referral process

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DSRIP Category II – Program Innovation and Redesign

	Project Area		Intervention	Outcome Measures
2	Test Financing Mechanisms for Providers	A	Develop a shared savings model between providers and payers.	TBD by RHP
		B	Create patient-directed wellness pilot that includes incentives, such as health navigation with flexible wellness accounts.	Number of participants. Monitor costs, savings, and clinical outcomes.

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DSRIP Category II – Program Innovation and Redesign

	Project Area		Intervention	Outcome Measures
3	Develop Innovations in Health Promotion/ Disease Prevention	A	Formalize relationships and referrals to community partners that have capacity to promote wellness and healthy behaviors.	Documented promotion of wellness and health behaviors.
		B	Utilize Community Health Workers (CHW) to expand access to health promotion and disease prevention behavior within current health promotion programs in RHP.	Develop CHW positions in RHP health promotion programs to assist/promote disease prevention education.
		C	Establish self-management education programs in community settings including self-enrollment in the program and appropriate follow-up with a health care professional. Engage in wellness at non-medical locations using CHWs.	% of retention and graduation rates for established classes # of new self management programs

DSRIP Category II – Program Innovation and Redesign

	Project Area		Intervention	Outcome Measures
3	Develop Innovations in Health Promotion/ Disease Prevention	D	Engage in population-based campaigns or programs to promote healthy lifestyles using new media such as social media and text messaging in an identified targeted population.	% of target population reached through new media components of healthy lifestyles campaigns or programs
		E	Implement a program to increase early enrollment in prenatal care.	%% of first trimester enrollment %% of women with no prenatal care
		F	Implement evidenced-based strategies to reduce low birth weight and preterm birth.	%% of preterm birth and low birth weight

DSRIP Category II – Program Innovation and Redesign

	Project Area		Intervention	Outcome Measures
3	Develop Innovations in Health Promotion/ Disease Prevention	G	Implement evidenced-based strategies to reduce tobacco use.	%% of tobacco use in target population and documentation of provider counseling
		H	Implement evidence-based strategies to increase exclusive breast feeding.	## of newborns who received exclusive breast milk feedings during the newborn's entire hospitalization (JC PC-05)

DSRIP Category II – Program Innovation and Redesign

	Project Area		Intervention	Outcome Measures
3	Develop Innovations in Health Promotion/ Disease Prevention	I	Implement evidence-based strategies to increase screenings for targeted populations.	% of target population screened
		J	Implement prevalence testing for high risk diseases as determined by Public Health Authority	% of target population screened

DSRIP Category II – Program Innovation and Redesign

	Project Area		Intervention	Outcome Measures
4	Develop Innovation for Provider Training and Capacity	A	Implement an integrated multi-disciplinary care system to promote team-based care.	Evidence of system plan that includes job descriptions and care pathways
		B	Develop chronic care multi-disciplinary training programs for nurses, pharmacists, social workers, registered dietitians and physicians.	% of multi-disciplinary team who participated in training program.

DSRIP Category II – Program Innovation and Redesign

	Project Area		Intervention	Outcome Measures
5	Enhance Behavioral Health Services	A	Develop care management function that integrates the primary and behavioral health needs of individuals.	Evaluation report of integrated care management services including rate of urgent care sought by individuals served Cost benefit analysis
		B	Co-locate primary and behavioral health care services.	# of integrated health providers # of encounters
		C	Provide telephonic psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally.	# of integrated health providers # of encounters

DSRIP Category II – Program Innovation and Redesign

	Project Area		Intervention	Outcome Measures
5	Enhance Behavioral Health Services	D	Establish post-discharge support for behavioral health/ substance abuse.	% of targeted population who received post discharge support from collaborative partner
		E	Recruit, train and support consumers of mental health services to be providers of behavioral health services as volunteers, paraprofessionals or professionals within the system.	## of encounters provided by peer mentors Rate of non-urgent care seekers

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DSRIP Category II – Program Innovation and Redesign

	Project Area		Intervention	Outcome Measures
6	Innovate in Telehealth	A	Leverage state government agencies, industry, and other organizations to offer online education to rural physician offices.	Online telehealth curriculum and % enrolled in telehealth curriculum
		B	Provide psychosocial, clinical, and behavioral case management services to promote independence and patient self-management at home via telehealth delivered by case managers who are integrated into primary care practices.	%% of eligible patients using telehealth for care

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DSRIP Category II – Program Innovation and Redesign

	Project Area		Intervention	Outcome Measures
7	Innovate in Supportive Care	A	Create a sustainable supportive care program to improve the quality of life of patients living with chronic or terminal conditions and to further engage care providers in the clinical benefits of supportive care.	%% of at-risk patient populations receiving outpatient supportive care service
		B	Standardize supportive care - decision-making with evidence-based protocols and documented health records to ensure that patient preferences are discussed/recorded.	_# hospitals/partners % of patients who show improved understanding of supportive care % of patients who use supportive care
		C	Partner with community-based organizations to address pain and other supportive care issues with patients.	# of partners who have a supportive care program. % of patients who are referred to supportive care

DSRIP Category II – Program Innovation and Redesign

	Project Area		Intervention	Outcome Measures
8	Reduce inappropriate Emergency Department (ED) Use	A	Standardize elements of an interdisciplinary supportive care team dedicated to alleviating patient suffering in a manner that prioritizes pain control, spiritual care and patient/family preferences.	%% of documented patients seen by the supportive care service %% of documented bereavement support services for families of patients who died while being seen by the supportive care service
		B	Establish ED care teams.	%% of admit decision time to ED departure time for admitted patients (NQF 0497)
		C	Reduce ED visits by identifying frequent users' needs.	# ED visits of target population for non-emergency diagnoses
		D	Develop and implement triage protocol.	# of ED visits for target population for non-emergency diagnoses

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DSRIP Category II – Program Innovation and Redesign

	Project Area		Intervention	Outcome Measures
9	Improve Patient Experience of Care	A	Survey patients using CAHPS Patient-Centered Medical Home (PCMH) Item Set.	Results of HCAHPs PCMH composite measures (Providers pay attention to your mental or emotional health {adult only}; providers support you in taking care of your own health; providers discuss medication decisions {adult only})
		B	Survey patients using CAHPS Cultural Competence Item Set.	Results of HCAHPs Cultural Competence composite measures (doctors are polite and considerate; doctors give advice on staying healthy; doctors are caring and inspire trust)

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Category III: Quality Improvements

- Congestive heart failure
- Asthma
- HIV
- SCIP
- Perinatal Outcomes
- PPA/PPR
- Emergency Care
- MDROs/CDI
- Facility-acquired pressure ulcers
- Birth Trauma

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DSRIP Category III – Quality Improvements

	Project Area		Focus	Outcome measures
1	Chronic Disease	A	Congestive Heart Failure	Documentation of discharge instructions (HF-1) and time interval between discharge and follow-up appointment Evaluation of LVS function (HF-2 ACEI or ARB for LVSD (HF-3) Adult smoking cessation advice/counseling (HF-4)
		B	Asthma	Relievers for inpatient asthma (age 2 years through 17 years) (CAC-1) Systemic corticosteroids for inpatient asthma (CAC-2) Home management plan of care document given to patient/caregiver (CAC-3)

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DSRIP Category III – Quality Improvements

	Project Area		Focus	Outcome measures
1	Chronic Disease	C	HIV	% of patients, regardless of age, with a diagnosis of HIV/AIDS with at least one medical visit in each 6-month period with a minimum of 60 days between each visit (NQF-0403) % of patients with CD4+ cell count or CD4+ cell percentage performed at least once every 6 months (NQF 0404) Patients with viral load below limits of quantification or patients with viral load not below limits of quantification who have a documented plan of care (NQF 0406) % of patients prescribed potent antiretroviral therapy (NQF 0407) Patients with viral load below limits of quantification or patients with viral load not below limits of quantification who have a documented plan of care (NQF 0406) % of patients with CD4+ cell count or CD4+ cell percentage performed at least once every 6 months (NQF 0404)

DSRIP Category III – Quality Improvements

	Project Area		Focus	Outcome measures
2	Healthcare Acquired Conditions	A	Surgical Site Infections (SSI)	SCIP-Inf-1 (prophylactic ABX received within one hour prior to surgical incision) SCIP-Inf-2 (prophylactic ABX selection for surgical patients) SCIP-Inf-3 (prophylactic ABX discontinued within 24 hours after surgery end time - 48 hrs post op for cardiac surgery) SCIP-Inf-4 (cardiac surgery patients with controlled 6 a.m. post-operative blood glucose) SCIP-Inf-9 (urinary catheter removed for post-operative day 1 or post-operative day 2 with day of surgery being day zero) SCIP-Inf-10 (surgery patients with perioperative temperature management) Reduce SSI rate (# of SSIs/# of patients)

DSRIP Category III – Quality Improvements

	Project Area		Focus	Outcome measures
2	Healthcare Acquired Conditions	B	MDROs/CDI	Prevalence rate of targeted organism (as reported in the NHSN CDI/MDRO module)
		C	Facility-acquired pressure ulcers	Reduction in hospital-acquired pressure ulcers, Stage II or greater (NQF 0201)

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DSRIP Category III – Quality Improvements

	Project Area		Focus	Outcome measures
3	Perinatal Outcomes	A	Birth trauma	Incidents of birth trauma (NQF 0474)
		B	Antenatal corticosteroid administration	Patients at risk of preterm delivery at ≥24 and <32 weeks gestation receiving antenatal corticosteroids prior to delivering preterm newborns (NQF 0476)
		C	Non-medically indicated delivery < 39 weeks	Patients with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed (Joint Commission PC-01)

DSRIP Category III – Quality Improvements

	Project Area		Focus	Outcome measures
4	Potentially Preventable Admissions/ Readmissions	A	Potentially Preventable Admissions/ Readmissions	Potentially preventable admissions rate and potentially preventable readmissions rate % of target patients who have a timely follow-up appointment (between 3 days and 2 weeks post-discharge)
		B	Behavioral Health - Potentially Preventable Admissions/ Readmissions	Potentially preventable admissions rate and potentially preventable readmissions rate % of behavioral health patients who have a timely follow-up appointment (between 3 days and 2 weeks post-discharge)

DSRIP Category III – Quality Improvements

	Project Area		Focus	Outcome measures
5	Emergency Care	A	Calculate baseline admit decision time to ED departure time for admitted patients.	Admit decision time to ED departure time for admitted patients (NQF 0497)

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Category IV: Population-based Improvement

- At-risk populations
- Preventive Health
- PPAs/PPRs
- Patient-centered health care
- Cost and Utilization
- Emergency Department

DSRIP Category IV – Population-based Improvements

	Project Area		Intervention	Outcome Measures
1	At-risk populations	A	Congestive Heart Failure	Heart failure admission rate (NQF 0330) % of admissions meeting CHF core measures
		B	Diabetes	Rate of lower-extremity amputation among patients with diabetes (NQF 0285)

DSRIP Category IV – Population-based Improvements

	Project Area		Intervention	Outcome Measures
2	Preventive Health	A	Immunizations	The percentage of patients age 5-64 with a high-risk condition or age 65 years and older who received the pneumococcal vaccine (NQF 0617) The percentage of patients discharged during October, November, December, January or February with pneumonia, age 50 and older, who were screened for influenza vaccine status and were vaccinated prior to discharge, if indicated (NQF 0149) The percentage of adolescents who had the recommended immunizations by their 13th birthday (NQF 1407) The proportion of the hospitals' employees who were vaccinated for flu during the current flu season
		B	Diabetes	Diabetes long-term complications admission rate (NQF 0274) Diabetes short-term complications admission rate (NQF 0272)
		C	Smoking cessation	Tobacco use assessment measure (NQF 28a) Tobacco cessation intervention measure (NQF 28b)

DSRIP Category IV – Population-based Improvements

	Project Area		Intervention	Outcome Measures
3	Potentially Preventable Admissions/ Readmissions	A	Behavioral health & substance abuse	30-day readmission rate for behavioral health/substance abuse Admission rate for behavioral health/substance abuse
		B	COPD	30-day readmission rate for COPD Admission rate for COPD
		C	Diabetes	30-day readmission rate for diabetes Uncontrolled diabetes admission rate (NQF 0638)
		D	All-cause	30-day readmission rate Admission rate
		E	Stroke	Admission rate for stroke
		F	Congestive Heart Failure	30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization (NQF 0330) Congestive heart failure admission rate (NQF 0277)

DSRIP Category IV – Population-based Improvements

	Project Area		Intervention	Outcome Measures
4	Patient-centered Health Care	A	Patient satisfaction	Ratings for the following composite HCAHPS and CAHPS domain survey question areas: Your care from doctors; your care from nurses, the hospital environment and when you left the hospital
		B	Medication management	Medication reconciliation levels in discharged inpatient population (NQF 0646)

DSRIP Category IV – Population-based Improvements

	Project Area		Intervention	Outcome Measures
5	Cost Utilization	A	Outpatient imaging	The proportion of MRI's of the lumbar spine with a diagnosis of low back pain with and without the patient having claims-based evidence of prior antecedent conservative therapy (NQF 0514)

	Project Area		Intervention	Outcome Measures
6	Emergency Department	A	Admit decision time to ED departure time	Admit decision time to ED departure time for admitted patients (NQF 0497)

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Comments on the DSRIP

Example

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Comments on the DSRIP

- Access the DSRIP at: http://www.hhsc.state.tx.us/1115-waiver.shtml

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Comments on DSRIP (example)

- Review Category III.

	Project Area		Focus	Outcome measures
4	Potentially Preventable Admissions/ Readmissions	A	Potentially Preventable Admissions/ Readmissions	Potentially preventable admissions and potentially preventable readmissions. Percentage of target patients who have a timely follow-up appointment (between 3 days and 2 weeks post-discharge).
		B	Behavioral Health - Potentially Preventable Admissions/Readmissions	Potentially preventable admissions and potentially preventable readmissions. Percentage of Behavioral Health patients who have a timely follow-up appointment (between 3 days and 2 weeks post-discharge).

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Comments on DSRIP
(example cont.)

- Existing Measure comment -- Fill out the tab labled “Cat III”.

Project Area /Focus	Outcome measures	Reasonable Project Area?	Reasonable Measure?	Availability of data to measure?	Comments
Project Area 4, Focus B.	Potentially preventable admissions and potentially preventable readmissions. Percentage of Behavioral Health patients who have a timely follow-up appointment (between 3 days and 2 weeks post-discharge).	Yes	No	Yes	Change 3d – 2w to 3d - 7d.

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Comments on DSRIP
(example cont.)

- New Measure Comment -- Fill out the tab labeled Cat III.

	Project Area		Focus	Outcome measures
4	Potentially Preventable Admissions/ Readmissions	B	Behavioral Health - Potentially Preventable Admissions/Readmissions	Potentially preventable admissions and potentially preventable readmissions. Percentage of Behavioral Health patients who have a timely follow-up appointment (between 3 days and 2 weeks post-discharge).
		C	Substance Abuse - Potentially Preventable Admissions/Readmissions	Potentially preventable admissions and potentially preventable readmissions. Percentage of Substance Abuse patients who have a timely follow-up appointment (between 3 days and 7 days post-discharge).

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Comments on DSRIP

- Send updated excel workbook with comments to TX-DSRIP@tmf.org by April 24, 2012 for consideration.
- Comments will be reviewed by TMF and HHSC.

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A DSRIP Menu Vision Revisited

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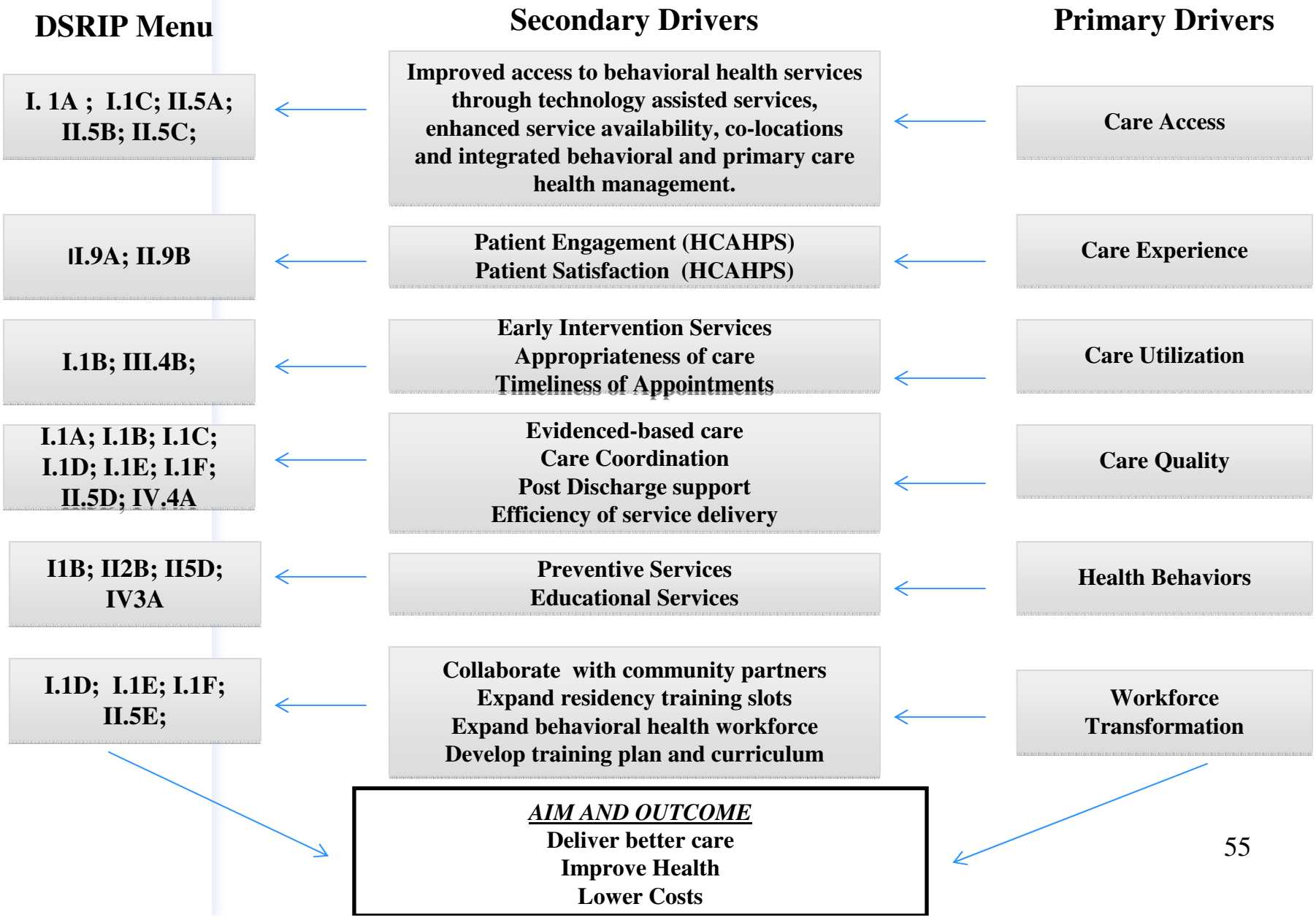
Expand Behavioral Health Care Access: Driver Diagram



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Resources/Contacts

- http://www.hhsc.state.tx.us/1115-waiver.shtml.
  - DSRIP Menu
  - DSRIP Stakeholder Comment Instructions
  - DSRIP Stakeholder Comment Powerpoint
- For any questions, comments, or concerns, please contact TX-DSRIP@tmf.org.